



Prior Authorization Request Form – Topical Immunomodulators (Elidel® & Protopic®)

Instructions:

This form is to be used by participating providers to request coverage for Topical Immunomodulator medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A Topical Immunomodulator step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are prescribed for the same indication. A trial of **two first-line generic topical corticosteroids** is required before the use of Elidel or Protopic. In addition, members less than 2 years of age must be followed by a dermatologist. If approved, quantity limits apply.

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & <u>Specialty</u> :	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number: Fax: ()	Tel: ()
Mailing Address:	

7. Requested Drug: <input type="checkbox"/> Elidel <input type="checkbox"/> Protopic	8. Dose, Frequency and Duration of Requested Drug:
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9. Diagnosis/Indication (<u>please specify affected areas to be treated</u>):

10. Has the member previously tried first-line topical corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list and indicate response (Please specify if hydrocortisone 1% OTC has been tried):			
Trial #1: _____	<input type="checkbox"/> side-effect	<input type="checkbox"/> inadequate response	<input type="checkbox"/> allergy
Trial #2: _____	<input type="checkbox"/> side-effect	<input type="checkbox"/> inadequate response	<input type="checkbox"/> allergy
Other (please specify): _____	<input type="checkbox"/> side-effect	<input type="checkbox"/> inadequate response	<input type="checkbox"/> allergy

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date